

Exhibit 16



CHOICE HOUSE CALL

17200 E. 10 Mile Rd. Suite 135

Eastpointe, MI 48021

Phone: (586) 279-3200 Fax: (586) 279-3184

Physical Therapy Prescription

Patients Name:

[Redacted Patient Name]

Date

1/20/10

Diagnosis: 1.

T + L spine

Diagnosis: 2.

Diagnosis: 3

Diagnosis: 4

Evaluate & Treat:

X

Area:

T + L spine

Evaluate & Treat:

Area:

Evaluate & Treat:

Area:

Evaluate & Treat:

Area:

Frequency:

3/wk

Duration:

4 wks

Onset Date:

1.6.10

Precautions:

Physician's Name:

Dr. R. Gunabalan

Physicians Signature:

R Gunabalan

Date:

1.20.10



CHOICE HOUSE CALL

17200 E. 10 Mile Rd. Suite 135

Eastpointe, MI 48021

Phone: (586) 279-3200 Fax: (586) 279-3184

Occupational Therapy Prescription

Patients Name:

[Redacted Patient Name]

Date

2/8/10

Diagnosis: 1.

T & L strain

Diagnosis: 2.

Diagnosis: 3

Diagnosis: 4

Evaluate & Treat:

X

Area:

T & L Spine

Evaluate & Treat:

Area:

Evaluate & Treat:

Area:

Evaluate & Treat:

Area:

Frequency:

3/wk

Duration:

4 wks

Onset Date:

1/6/10

Precautions:

Physicians Name:

R. Gunabalan MD

Physicians Signature:

R. Gunabalan

Date:

2/8/10



CHOICE HOUSE CALL

17200 E. 10 Mile Rd, Suite 135

Eastpointe, MI 48021

Phone: (586) 279-3200 Fax: (586) 279-3184

Physical Therapy Prescription

Patients Name:

[Redacted Patient Name]

Date

3/1/10

Diagnosis: 1.

T & L zone

Diagnosis: 2.

Diagnosis: 3

Diagnosis: 4

Evaluate & Treat:

^

Area:

T & L zone

Evaluate & Treat:

Area:

Evaluate & Treat:

Area:

Evaluate & Treat:

Area:

Frequency:

3/wk

Duration:

4 wks

Onset Date:

1-6-10

Precautions:

Physicians Name:

R. Gunabalan MD

Physicians Signature:

R. Gunabalan

Date:

3-1-10



CHOICE HOUSE CALL

17200 E. 10 Mile Rd. Suite 135

Eastpointe, MI 48021

Phone: (586) 279-3200 Fax: (586) 279-3184

Occupational Therapy Prescription

Patients Name:

[Redacted Patient Name]

Date:

3/1/10

Diagnosis: 1.

Post-Op Headaches

Diagnosis: 2.

Diagnosis: 3

Diagnosis: 4

Evaluate & Treat:

X

Area:

headaches

Evaluate & Treat:

Area:

Evaluate & Treat:

Area:

Evaluate & Treat:

Area:

Frequency:

3 times

Duration:

4-5 hrs

Onset Date:

1-6-10

Precautions:

Physicians Name:

R. Gunabalan MD

Physicians Signature:

R. Gunabalan

Date:

3/1/10

Phone 5/994-1170



CHOICE HOUSE CALL

17200 E. 10 Mile Rd. Suite 135

Eastpointe, MI 48021

Phone: (586) 279-3200 Fax: (586) 279-3184

Physical Therapy Prescription

Patients Name:

[Redacted Patient Name]

Date

3-21-10

Diagnosis: 1.

Cervical + Lumbar Rad.

Diagnosis: 2.

Diagnosis: 3.

Diagnosis: 4.

Evaluate & Treat:

X

Area:

C & L Spine

Evaluate & Treat:

Area:

Evaluate & Treat:

Area:

Evaluate & Treat:

Area:

Frequency:

3/wk

Duration:

4 wks

Onset Date:

Precautions:

Physicians Name:

Quirra

Physicians Signature:

[Signature]

Date:

3/31/10



CHOICE HOUSE CALL

17200 E. 10 Mile Rd. Suite 135

Eastpointe, MI 48021

Phone: (586) 279-3200 Fax: (586) 279-3184

Physical Therapy Prescription

Patients Name: _____

Date: 5/10/10

Diagnosis: 1. C & L spine Rto Rad.

Diagnosis: 2. _____

Diagnosis: 3. _____

Diagnosis: 4. _____

Evaluate & Treat: X

Area: C & L spine

Evaluate & Treat: _____

Area: _____

Evaluate & Treat: _____

Area: _____

Evaluate & Treat: _____

Area: _____

Frequency: 3/wk

Duration: 4 wks

Onset Date: 3/21/10

Precautions: _____

Physicians Name: M. Quiroga DO

Physicians Signature: [Signature]

Date: 5/10/10



CHOICE HOUSE CALL

17200 E. 10 Mile Rd. Suite 135

Eastpointe, MI 48021

Phone: (586) 279-3200 Fax: (586) 279-3184

Occupational Therapy Prescription

Patients Name:

[Redacted Patient Name]

Date

5/10/10

Diagnosis: 1.

Post Traumatic Headaches

Diagnosis: 2.

(R) Rib Contusion

Diagnosis: 3

Diagnosis: 4

Evaluate & Treat:

X

Area:

(2) Ribs

Evaluate & Treat:

X

Area:

Head

Evaluate & Treat:

Area:

Evaluate & Treat:

Area:

Frequency:

3/wk

Duration:

4 wks

Onset Date:

Precautions:

Physicians Name:

M. Quinonez DO

Physicians Signature:

[Handwritten Signature]

Date:

5/10/10



22 B129305

17200 E. 10 Mile Rd. Suite 135
Eastpointe, MI 48021
Phone: (586) 279-3200 Fax: (586) 279-3184

Physical Therapy Prescription

Patients Name: _____

Date: 6/23/10

Diagnosis: 1. CTL Strain

Diagnosis: 2. _____

Diagnosis: 3. _____

Diagnosis: 4. _____

Evaluate & Treat: X

Area: CTL Spinal

Evaluate & Treat: _____

Area: _____

Evaluate & Treat: _____

Area: _____

Evaluate & Treat: _____

Area: _____

Frequency: 3 times/week Duration: 4 weeks Onset Date: _____

Precautions: _____

Physicians Name: _____

Martin Quiroga, DO

Physicians Signature: [Signature]

Date: 6/23/10



17200 E. 10 Mile Rd. Suite 135
Eastpointe, MI 48021
Phone: (586) 279-3200 Fax: (586) 279-3184

Occupational Therapy Prescription

Patients Name: [Redacted] Date 6/23/10

Diagnosis: 1. Post traumatic H.A.

Diagnosis: 2. _____

Diagnosis: 3 _____

Diagnosis: 4 _____

Evaluate & Treat: X Area: Head

Evaluate & Treat: _____ Area: _____

Evaluate & Treat: _____ Area: _____

Evaluate & Treat: _____ Area: _____

Frequency: 3 times/week Duration: 4 weeks Onset Date: _____

Precautions: _____

Physicians Name: Martin Quiroga, DO

Physicians Signature: [Signature] Date: 6/23/10

~~Coming~~
~~Nov 13~~



17200 E. 10 Mile Rd. Suite 135
Eastpointe, MI 48021
Phone: (586) 279-3200 Fax: (586) 279-3184

Occupational Therapy Prescription

Patients Name [Redacted] Date 10/27/10

Diagnosis: 1. Post MVA H.A

Diagnosis: 2. _____

Diagnosis: 3 _____

Diagnosis: 4 _____

Evaluate & Treat: X Area: Head

Evaluate & Treat: _____ Area: _____

Evaluate & Treat: _____ Area: _____

Evaluate & Treat: _____ Area: _____

Frequency: 3 times/week Duration: 4 weeks Onset Date: _____

Precautions: _____

Physicians Name: Martin Quiroga, DO

Physicians Signature: [Signature] Date: 10/27/10



17200 E. 10 Mile Rd. Suite 135
Eastpointe, MI 48021
Phone: (586) 279-3200 Fax: (586) 279-3184

Occupational Therapy Prescription

Patients Name: [Redacted]

Date 9/22/10

Diagnosis: 1.

Post Concussive H.A.

Diagnosis: 2.

Diagnosis: 3

Diagnosis: 4

Evaluate & Treat: X

Area: Head.

Evaluate & Treat:

Area:

Evaluate & Treat:

Area:

Evaluate & Treat:

Area:

Frequency: 3 times/week Duration: 4 weeks Onset Date:

Precautions:

Physicians Name: Martin Quiroga, DO

Physicians Signature: [Signature]

Date: 9/22/10



MUNDY PAIN CLINIC
6240 RASHELLE DR. SUITE 103 FLINT, MI 48907
PHONE: 810-232-9800, FAX: 810-232-7710

Occupational Therapy Prescription

Patient's Name:

[Redacted Patient Name]

Date:

2/8/11

Diagnosis: 1.

CMT 1st concave h/p

Diagnosis: 2.

(P) Phil dent

Diagnosis: 3

Diagnosis: 4

Evaluate & Treat

2

Area:

bal

Evaluate & Treat:

2

Area:

(P) Phil

Evaluate & Treat:

Area:

Evaluate & Treat:

Area:

Frequency: 3 times/week

Duration:

4 weeks

Onset Date:

Precautions:

Physician's Name

Andrew Ruder M.D.

Physician's Signature:

Date:

2/8/11

Jan. 5 2011 3:28PM

No. 9593 P. 2

2940

06110621000246P



EPA

MUNDY PAIN CLINIC

6040 RASHELLE DR. SUITE 103 FLINT, MI 48507
PHONE: 810-332-9800, FAX: 810-332-7710

Occupational Therapy Prescription

Patient's Name:

Date:

1/4/11

Diagnosis: 1.

L shoulder

Diagnosis: 2.

past MVA h/c

Diagnosis: 3

Diagnosis: 4

Evaluate & Treat:

X

Area:

head

Evaluate & Treat:

X

Area:

L shoulder

Evaluate & Treat:

Area:

Evaluate & Treat:

Area:

Frequency: 3 times/week Duration: 4 weeks Onset Date: 4/27/10

Precautions:

Physician's Name:

Andrew Ruden M.D.

Physician's Signature:

Date: 1/4/11